



APPLICATION FOR CHILD CARE SERVICES

State Form 46513 (R4 / 11-08) / BCD 0805

SECTION A - Child Care Services are hereby requested by or on behalf of Applicant (Head of Family)				
1. Name of applicant (last name, first name, middle initial)				
2. Address (number and street, city, state, and ZIP code)				

3. Single parent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	4. County of residence number	School district number	5. Telephone number ())	
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SECTION B - Family Members - Complete this section for yourself and ALL FAMILY MEMBERS living in your household. Be sure to complete ALL information. (See definition of family on instruction sheet.)																	
Last Name	1. First Name	M.I.	2. Date of Birth	3. Citizen?	4. Custodial adult?	5. Relationship to applicant	6. Gender	7. Recipient Identification Number	8. Medicaid/ Hoosier Healthwise?	9. TANF?	10. Ethnic Hispanic or Latino?	11. Race Circle Y or N in EACH box (see codes below)**					12. Adult Service Need Code+
Head of family is to be listed first.																	
				Y / N	Y / N	SELF	M / F		Y / N	Y / N	Y / N	1	2	3	4	5	
				Y / N	Y / N		M / F		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	
				Y / N	Y / N		M / F		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	
				Y / N	Y / N		M / F		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	
				Y / N	Y / N		M / F		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	
				Y / N	Y / N		M / F		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	
				Y / N	Y / N		M / F		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	

SECTION C - Family Income and Size - List the income received (in the last 30 days) by family members living in your household. Income for children under 16 years of age (except SSI and TANF) need not be reported.

1. Name of Person Receiving Money	2. Monthly Gross Income for Eligibility Purposes	3. Income Source Code(s) (see codes)++										
4. # of adults in family	5. # of children in family	6. Total # in family	7. Total family income	8. Poverty level								

* Disclosure of your Social Security number (SSN) is optional. Your SSN is not required for child care eligibility and eligibility will not be denied due to your failure to provide a SSN. If provided, the State will keep your SSN confidential. State may use your SSN to assemble research data sets that do not identify individuals; verify employment and / or income; supply the federal government information regarding the child care program; and / or match against TANF database.

**RACIAL / ETHNIC CODE (Section B.11)	+SERVICE NEED CODE (Sect. B.12)
1. American Indian / Alaskan Native	1. Employment / On The Job Training
2. Asian	2. Training / Education
3. Black or African American	3. Both 1 and 2
4. Native Hawaiian / other Pacific Islander	4. Child Protection Services
5. White	5. Other (new job, job search)
6. Multiracial	Explain:

++Income Source Codes (Section C.3)	
1. Wages/Employment	_____
2. TANF	_____
3. Other State funding	_____
4. Housing voucher / Cash assistance	_____
5. Food Stamps	_____
6. SSI or other Federal cash program	_____
7. Pension	_____
8. Unemployment	_____
9. Child Support	_____
10. Other (Interest, trust, etc.)	_____
11. Other (not counted in eligibility)	_____
DO NOT COUNT #3, #4, #5, or #11 toward eligibility	TOTALS _____

SECTION D - Education level of all adult members including begin/end dates for all those attending school / education / preschool

1. Name (last, first, M.I.)	2. Highest grade completed	3. Highest degree attained	4. Start date (month, day, year)	5. End date (month, day, year)	6. Receiving preschool services through child care program?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION E - Signature

I understand:

_____ and hereby certify that all the above information, provided by me, is true and correct to the best of my knowledge.

_____ that I may be requested to verify these statements and give my consent to the agency, from where I am requesting services, to make any necessary contacts to verify any statements.

_____ that I have the right to treatment that is fair and does not discriminate. I will not be treated differently because of color, race, national origin, religion, sex, age, political beliefs, marital status, or because of a physical, mental, or emotional condition.

_____ that I must report changes to the voucher agent within ten (10) calendar days.

_____ that the information I have given is private and cannot be seen by the public.

_____ that this program is not an entitlement and, therefore, I may be placed on a waiting list.

_____ that as a custodial, single TANF client, I will not receive penalties associated with work requirements if I cannot obtain child care for my children under 6 years of age.

_____ that failure to pay any child care co-pay could result in my family being terminated from this funding assistance.

_____ that if I fail to use my child care assistance within 60 days, it will be voided.

_____ my Rights and Obligations and have received a copy of them at the time of application.

_____ that if I receive CCDF benefits to which I am not entitled, for whatever reason, I shall be required to repay the State such amounts and I will be offered a repayment agreement by the State with a monthly payment option.

Signature of applicant	Date (month, day, year)	or TANF referral date (month, day, year)	Signature of agency	Date (month, day, year)
Original date of application (month, day, year)	Date child care subsidy begins	Date child care subsidy ends	Name of agency	
Eligibility determination date (month, day, year)	Re-determination date (month, day, year)			

SECTION F - Other Services Referred To

<input type="checkbox"/> Resource and Referral	<input type="checkbox"/> Brochures on Quality Child Care	<input type="checkbox"/> Complaint Process / Policies	<input type="checkbox"/> Health/Safety Information
<input type="checkbox"/> Regulatory Information	<input type="checkbox"/> Legal Child Care Information	<input type="checkbox"/> Mass Media Info Sites	<input type="checkbox"/> Subsidy Information
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> None

Application For Child Care Services: Bureau of Child Development
Instructions for completing SF 46513 / BCD 0805

NOTE: All information on this form is required for Federal or State reporting requirements. ALL information MUST be collected prior to determining eligibility: including Social Security Numbers for applicant(s) and children.

For the purposes of this program **FAMILY** is defined as: One or more adults and children, related by blood or law, residing in the same household. Where adults other than spouses reside together, each is considered a separate family. Wards of the Local Office of Family and Children are the legal responsibility of the local Office of the Division of Family and Children and not the family with which the child has been placed.

COMPLETE ALL UNSHADED AREAS / SHADED AREAS WILL BE COMPLETED BY THE VOUCHER AGENT:

Section A: Applicant Information

1. Full name of applicant (*head of family*)
2. Full mailing / physical address of applicant
3. Circle if the applicant is legally single. NA is appropriate only for children who are wards of the court through the Office of Family and Children.
4. Name / county ID number of the applicants resident county and School District Number.
5. Phone of applicant or contact phone number.

Section B: Applicant Family Information

1. Include names for all FAMILY members living in the household.
2. List date of birth for all family members.
3. Y if a US citizen and N if not a US citizen
4. Y if adult family member is a custodial parent and N if not.
5. List relationship to applicant (*son / daughter / boyfriend / grandchild, etc.*)
6. Gender Code only. 1 for Male / 2 for Female
7. Recipient Identification number is mandatory to be eligible for child care assistance.
8. Indicate if each family member is a Medicaid or Hoosier Healthwise participant with a Y or N.
9. Indicate if family member is a TANF recipient or not by Y or N.
10. Indicate, by using Y or N, if each family member is of Hispanic or Latino ethnic background.
11. Find the Race Code number at bottom of page. Each column MUST have a Y / N for each race indicator.
12. Use the Service Need Code number at the bottom of page to indicate service need OF THE ADULT FAMILY MEMBERS.

Section C: Family Income / Size Information

1. Include the name of each person receiving income/
2. Total gross monthly amount for income received in the previous 30 days. Use the INCOME SOURCE info at the bottom of page to total all income. Income of children under 16 yrs. is not counted, except TANF and SSI. Income reported in # 3,4,5 and 11 are reported, and can be declared by applicant, however is NOT used in determining eligibility. NO income is counted for Service Need #4: Child Protection Services.
3. List all Income Source Codes for each individual.
4. Total number of adults in family.
5. Total number of children in family.
6. Total number in family.
7. Total family income.
8. Poverty level of family based on scale.

Service Codes: Use these boxes / codes to complete the family information. In determining income be sure to subtract income from lines 3, 4, 5, and 11 before determining eligibility. Income on these lines may be declared by the applicant, available documentation should be included in the family file.

Section D: Education

To be completed for each family member as follows:

1. Name of family member.
2. Highest grade level completed by each adult family member.
3. Highest degree attained by each adult family member.
4. Start date of school for current year, if applicable.
5. End date of school for current year, if applicable.
6. Indicate with a Y or N if a preschool age child is receiving Preschool Services through the child care provider site.

Section E: Signatures: space has been provided along each statement for parent to initial upon reading statement.

Applicant MUST read or have read these statements, sign and date form prior to determining eligibility.

Agency person MUST sign and date

Original Date of Application: The date the family first came in and applied for assistance. This date will remain the same .

The duration of the family receiving assistance UNLESS there is a greater than 3 month break in service.

Date of Eligibility: Date family is determined eligible by Voucher Agent.

Date Child Care Subsidy Begins: First service need date that will be covered through funding.

Date Child Care Subsidy Ends: Last date of eligibility as determined by this 805 application.

Re-determination date: Date the family will need to make appointment to complete new 805.

Section F: Other Services

This section will be used to document any referrals for other appropriate services need by family.

Write in others as appropriate. If no services were offered check NONE.

Provider sheet instructions:

COMPLETE THIS PAGE FOR EACH PROVIDER the family is using at the time of application or when the family is changing child care providers.

NOTE: Parent or provider will complete the unshaded aread / Voucher agent will complete shaded areas.

Section G: Provider Information

1. Name of provider
2. Telephone number where care is being provided.
3. Social Security Number or Employer Identification Number of provider.
4. Name of business or child care facility if other than name of provider.
5. Address of LOCATION OF CARE / mailing address.
6. City of location / mailing address
7. Zip code of location. If the provider is out-of-state, indicate this in this square.
8. County where care is located.
9. Type of care. From the code list in the box, place the number on the line that fits the description of the care facility / provider.
10. License or Registration Number / capacity number / number of sites for licensed or registered providers.
11. For Legally-Licensed Exempt home providers only: Date of birth / Age / Relationship to child, if any, of exempt provider.
12. This space can be used by the agency / provider to add additional information.

Section H: Child Care Needs / Expenses: Place family surname on line provided.

1. Name of each child in need of child care assistance.
2. Y / N for showing Proof of Special Needs: Documentation of Special Needs required (*Children with Special Health Care Services / First Steps / Special Education in Public School / Supplemental Security Income / Head Start enrolment for professionally diagnosed children with disabilities*) See manual for further clarification.
3. Place any additional costs associated with the special needs here (*10% allowable over Market Rate*).
4. Total hours needed per week based on service need.
5. Place the number of hours per day and the number of days per week of service need for each child.
6. Actual charge per service need established.
7. Indicate the county market rate in the column that fits the service need for each child.
8. Indicate any overcharge the family will be responsible for (*6-7 = 8: Charges minus Market Rate*).
9. Indicate the family co-pay per pay / week (*see * at bottom of table of 805*).
10. Actual child care subsidy using the formula at the ** bottom of the table on the 805.
11. Identify funding source # to be used for each child using the *** at bottom of table on the 805.

Signature of the provider and date is required.

Shaded box to be completed by Voucher Agent:

Date To Meet Minimum Standards: If your county has implemented Minimum Standards, indicate the date this provider has to complete them.

Date For Provider Re-Certification: Providers must be re-certified at least annually. Recert date may be the license, registration, or minimum standards must be renewed.